

## New Terms of Reference for the ISO

Over the last 3 years, at the request of the ISO, the ISO Board has been reviewing the ISO's Terms of Reference ("TOR"). The ISO's aim was to clarify and simplify the TOR for the use of consumers, Participants and the ISO Office. The review was also intended to align the TOR with the ISO Office's current practices.

The new TOR were effective from 1 July 2002 and will apply to all complaints received from 1 July 2002.

We have included a copy of the new TOR with this issue of *Assessment*. In addition to the new TOR, there are Guidelines for the proper interpretation of the definition of "Personal Line Insurance Services", which have been agreed between the ISO and the Insurance Council of New Zealand Inc. ("ICNZ"), as follows:

"Personal Line Insurance Services" being any services by way of personal and domestic insurance policies covering:

- (a) house
- (b) contents
- (c) personal property and liability
- (d) private motor vehicle
- (e) travel
- (f) private pleasure craft

but excluding policies issued in connection with any commercial or trade activity.

The following categories of "Personal Line Insurance Services" shall be included:

**Farm or Lifestyle Insurance** - personal house and contents, private motor vehicle, and private pleasure craft insured under a farm or lifestyle policy;

**Contract Works Insurance** - an insurance policy in the name of the homeowner covering a private house under construction or alteration exclusively by the homeowner;

**Public Liability Insurance** - public liability incurred by the insured in the course of private and domestic activities, not being cover for public liability arising in the course of any commercial or trade activity;

**Vendors' Warranty Extension Insurance** - motor vehicles, marine motors, appliances and other personal property of the insured (used solely for private and non-commercial purposes) by way of extension to a manufacturer's or vendor's warranty;

**Private Aircraft Insurance** - personal property includes private aircraft insurance for non-commercial use; and

**Consumer Credit Insurance** - consumer credit insurance policies issued for private hire purchase repayment protection.

The following category of "Personal Line Insurance Services" shall be excluded:

**Tenanted Property Insurance** - tenanted properties. However, at the request of the ISO, a Participant may agree to include a particular property.

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## CONSUMER FORUM

26 August 2002  
Crowne Plaza Hotel  
Auckland

Hosted by the Banking Ombudsman, the Electricity Complaints Commissioner and the ISO.

For further details please contact us on 0800 888 202

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*In this publication, the Insurance & Savings Ombudsman is referred to as the ISO. In the case studies, the letter "P" is used to denote Participant and "C" to denote Complainant.*

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Published by:  
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## Materiality for Non-disclosure on Applications for Insurance (particularly health and disability)

When considering complaints relating to the non-disclosure of material information, this Office considers the following 3 questions:

*What information was disclosed?*

*What information should have been disclosed?*

*Was the information material?*

One of the key considerations is the materiality of the information which the insured failed to disclose on the application. When the complaint concerns disability or health insurance, this commonly relates to the Complainant's medical history.

The information which the insured failed to disclose is material only if it would have influenced the mind of a prudent insurer in fixing the premium or determining whether the risk would have been taken or continued on the same terms. In *Carter v Boehm* (1766) 3 Burr 1905, 1 Wm Bl 593, 97 ER 1162 (cited in *Legal Decisions Affecting Insurance 1729-1991 Vol I*, 13 [and referred to in *State Insurance Ltd v Brightwell* (16 August 2001), unreported, High Court, Hamilton Registry, AP 29/01]), the court referred to how the underwriter was induced into the contract on the basis of the information provided by the insured. Hammond J in *Brightwell*, outlined the New Zealand position at page 11, when he stated "*Information is material when it would affect the ultimate decision of the insurer in terms of acceptance or rejection of insurance, the setting of premiums and the attachment of conditions.*"

When the materiality of the information is at issue, we ask other prudent underwriters for their opinions to determine if the information would have been material to their decision to insure. This involves giving prudent underwriters an anonymised fact scenario and asking how they would have underwritten the application.

Often when the information concerned is the medical history of the applicant, a prudent insurer is not immediately able to indicate how he or she would have underwritten that application because, if the information had been disclosed, further enquiries would have been made with the insured or the insured's doctor.

Information is not material if it would only have led to the insurer making further enquiries. The insurer must show how it would have affected its decision to insure (refer *Brightwell* and *Barclay Holdings (Australia) Pty Ltd v British National Insurance Co Ltd* [1987] 8 NSWLR 514).

In the Court of Appeal's decision in *Barclay Holdings*, Kirby P stated that the test of materiality must relate to the insurer's decision to insure, rather than the process by which a decision would have been made. Kirby P stated at pages 517-519 that the effect on the prudent insurer should be, as follows:

*"... more than the effect produced by information which the insurer would have been generally interested to have. If, though interested to have it, such information would not, in the end, have determined for a reasonably prudent insurer the acceptance or rejection of insurance, the setting of the premium or the attachment of conditions, there is not such effect on the mind as requires disclosure by the insured. The information, although of interest, is not material. As such it is not information which must be disclosed by the insured.*

### Case Study 1

C made a claim to P for a disability benefit under her income protection policy. During its consideration of C's claim, P discovered that C had a history of prescriptions for pain relief and sleeping tablets which were not disclosed on the application.

P declined to consider the claim and avoided the policy, on the basis that C failed to disclose material information on the application.

From the information provided, it was clear that C had failed to disclose a number of prescriptions for sleeping tablets, together with prescriptions for pain relief. While C argued that she had a different understanding of the application questions, or had simply forgotten the prescriptions, the Case Manager believed that the application question clearly indicted C must disclose prescription medication.

The question was then whether the information was material. P's underwriter stated that, had C disclosed the prescriptions, further information would have been requested from C. But, because C failed to disclose this information, the underwriter was unable to make an informed decision, as there was insufficient information upon which to assess the risk. P's underwriter stated he was denied the opportunity to complete a prudent assessment.

However, the underwriting opinion did not indicate how the information would have influenced the prudent insurer's decision to insure. Therefore, in order to determine materiality, the Case Manager asked P's underwriter what further information would have been required had C disclosed the prescriptions on the application. P's underwriter would have asked C and her doctor to complete additional questionnaires if the information had been disclosed. The Case Manager asked C and her doctor to complete these questionnaires as they would have done when C took out the insurance. The Case Manager also obtained further information about the prescriptions given by C's doctor.

The Case Manager then presented this fact situation, including the additional questionnaires, to a number of prudent underwriters. The majority of prudent underwriters indicated the information would have affected their decision to insure C and that they would have placed a mental health exclusion on the policy if the information had been disclosed. On this basis, the Case Manager believed that the prescriptions were material information which C failed to disclose. Therefore, P was entitled to rely on this non-disclosure to decline to consider the claim and avoid the policy.

*...If the circumstance which is not disclosed would, although of general interest to the insured (sic), have been discarded in determining whether or not to accept insurance and, if so, at what premium and on what conditions, then the failure to disclose the circumstance is not relevant to the purpose for which this obligation has been imposed by the law."*

This test was adopted by Cooke P, in *State Insurance General Manager v McHale* [1992] 2 NZLR 399 at pages 402-3. The approach taken in *McHale* was referred to and adopted by the court in *Royal & Sun Alliance Life and Disability (New Zealand) Limited v Laurence* (1999) 10 ANZ Insurance Cases ¶61-434, by Laurenson J at page 74,934.

Therefore, more information may have to be gathered to enable an underwriter to indicate how the application would have been underwritten. This may involve retrospectively completing questionnaires, or providing more information as would have been done at the time of the application, had the information been disclosed. It is only then that a prudent insurer's opinion can indicate whether or not the information was material to the decision to insure.

See Case Study 1



## Cover under Travel Insurance Policies

With an increased public awareness of the dangers of travel, consumers must think carefully about travel insurance. A recent item on *Fair Go* has highlighted some of the common complaints to the ISO about travel insurance.

Some of the key issues consumers must be aware of when taking out travel insurance include: the disclosure of all material information on the proposal, exclusions for pre-existing conditions and the limitations on cover under a travel insurance policy.

For travel insurance, it is important to disclose all the information the applicant has knowledge of which an insurer would regard as material to its decision to insure the applicant. This includes recent doctor's visits or medical treatment, particularly if there has been any change in health or medication after the start of the policy, but before the travel commences. If the applicant does not tell an insurer something which would have affected its decision to insure the applicant, then it can decline to consider a claim and treat the policy as if it had never existed.

Many travel policies include specific exclusions for pre-existing conditions. The wording of these exclusions vary, so it is important that consumers read the policy to see what kind of cover for pre-existing conditions is available.

Sometimes, cover is excluded for anything which existed, or which was diagnosed prior to the start of the policy. Some insurance companies will offer cover for pre-existing conditions, if an additional premium is paid. The ISO advises consumers it is a important to discuss any pre-existing condition or symptoms with the insurer when taking out travel insurance.

As a result of her experience of complaints, the ISO advises consumers that it is very important to thoroughly read the policy document when they take out travel insurance. Often the cover offered in such policies is very specific, especially death cover. Most policies cover "death by accident." However, this cover is strictly defined in the policy so, although a death may be unexpected and unforeseeable, it may not be covered under a policy.

### Case Study 2

C took out travel insurance with P for her holiday overseas. On her return to New Zealand, after disembarking from the aircraft, C collapsed and was attended to by paramedics who advised her to go home. C subsequently died as the result of pulmonary thromboembolism ("PTE"). C's estate made a claim under the policy for C's death.

P declined to consider the claim, on the basis that C's death was not the result of an injury and was not covered under the policy. C's estate argued that C's death was the result of PTE or deep vein thrombosis ("DVT") caused by long distance air travel.

The policy provided cover for death as the result of "Injury", defined in the policy as "bodily injury caused solely and directly by violent, accidental, external and visible means".

The Case Manager considered the courts' interpretation of this definition and the facts of the estate's complaint, in the context of the following elements of the definition:

"bodily injury"

- The courts have held that it is not necessary for there to be an outward sign or visible injury to constitute a "bodily injury". Fisher J in *Jason v Batten (1930) Ltd* [1969] 1 Lloyd's Rep 281, stated that Coronary Thrombosis was a bodily injury and, on this basis, the Case Manager believed PTE and DVT could be considered a "bodily injury".

"solely and directly"

- The term "solely and directly" required the injury to be proximately caused by violent, accidental, external and visible means. The post mortem report stated the cause of C's death was PTE and noted that air travel is a recognised risk factor for the development of DVT and PTE. Although the link between DVT and air travel has recently received a lot of media attention, scientific opinion is inconclusive.

The Case Manager referred to 2 recent reports by the House of Lords and the World Health Organisation. Both reports concluded that, while there was a likely link between DVT and air travel, there were a number of other risk factors which would also contribute to an individual developing DVT. The Case Manager noted that C had some of these other risk factors. The Case Manager believed that, although air travel may increase the risk of DVT, the contention that it was the sole or proximate cause of C's death could not be supported.

For example, most travel insurance policies do not cover death by Deep Vein Thrombosis (DVT) because it is not caused by a violent external force, just as it is unlikely such a policy would cover death by heart attack or stroke. However, such a policy would probably cover any medical expenses incurred overseas, as the result of such an event.

The ISO, Karen Stevens, offers a warning to all consumers: “*When taking out travel insurance, read the policy to ensure you know what cover is available and make sure that you have told the insurance company everything it needs to know. Otherwise, you may find you have no insurance cover.*”

See Case Studies 2 and 3



## Internal Complaints Procedures

Internal complaints procedures were addressed in a recent article in SOCAP’s\* *Consumer Directions* June 2002 publication, by Bill Dee, the Australian chair of the International Standards Organisation working group drafting the international standard on complaints handling. Mr Dee stated the basic features of a complaints handling system include:

- *Visibility* – customers know where to complain.
- *Accessibility* – customers know how to complain.
- *Responsiveness* – complaints are dealt with quickly; the quicker they are dealt with, the higher customer satisfaction.
- *Fairness and objectivity* – the complaint should be judged on its merits and dealt with fairly.
- *Customer-focused approach* – invite complaints and indicate commitment to resolving complaints by words (publicise procedure) and actions (staff are aware of the policy and procedures).
- *Accountability* – someone must be responsible for complaints handling.
- *Continuous improvement* – use the complaints data to look at the root causes of the problems and address them.

\* SOCAP – Society of Consumer Affairs Professionals in Business Australia Inc.

The operation and function of the complaints procedure is central to its effectiveness. If there is no actual implementation of a complaints process, then internal complaints handling is a policy rather than procedure.

One of the common complaints we get from consumers about the way in which their complaints were handled by Participants, is the lack of communication and time it took to reach a position of “*deadlock*”. These 2 observations are inter-related, because often it is just a matter of informing the consumer at what stage their complaints are within the process. We believe that, if consumers are kept up-to-date about the consideration of their complaints, they feel informed and included in the process. For instance, often the process is held up when further information is being sought from an outside source. We believe that it is good practice to inform consumers about the reasons for the delay, which may also include an explanation as to why the further enquiries are being made.

The ISO believes that, in addition to its obligation under the ISO’s Rules to publicise the ISO Scheme, a Participant should also ensure its policyholders are aware of its internal complaints procedure, which will in turn form part of the

### Case Study 2 continued

“*violent* [means]”

- The Case Manager considered whether C’s death could be considered to have been caused by “*violent*” means. In *Hamlyn v The Crown Accidental Insurance Co Ltd* [1893] 1 QB, 750, Lord Escher stated that the phrase “*violent*” means the antithesis of “*without any violence at all*”. The Case Manager’s research indicated that the dominant factor in DVT associated with air travel is the long period of immobility related to long haul flights and, therefore, did not constitute by “*violent*” means.

“*accidental* [means]”

- The Case Manager believed that, in order for the death to have been caused by “*accidental*” means, the cause of the death must be accidental, that is it occurs as an unexpected result or there is an intervening cause in a voluntary action (refer *Hamlyn, Long v Colonial Mutual Life Assurance Society Ltd* [1931] NZLR 528, *Groves v AMP Fire & General Insurance Co (NZ) Ltd* [1990] 2 NZLR 408). However, the medical evidence did not support the conclusion that there was an intervening external cause, such as the reaction to the anaesthetic in *Groves*, which produced the DVT in C. A thrombus developed and it was this thrombus which caused C to suffer PTE.

“*external and visible means*”

- In *Hamlyn* at page 435, Lord Esher MR stated “[t]he word ‘*external*’ ...must be taken to mean the antithesis of ‘*internal*.’” There was no external or violent force that caused the thrombus to develop. Therefore, the Case Manager believed that the medical evidence established the cause of C’s death was internal, rather than external. It has been held that any cause which is external must be visible and the cause of C’s death could not have been by “*visible*” means.

Therefore, C’s death was not covered under the policy as it was not caused by an “*Injury*”.

### Case Study 3

C underwent Total Knee Replacement Surgery (“the surgery”), because he had been suffering from Osteoarthritis. Following the surgery, C’s doctor agreed it was safe for C to travel, so C and his wife booked and paid for a cruise, which entitled them to travel insurance with P.

C telephoned P to request cover for pre-existing conditions. In a file note

company's process for monitoring the quality of its products and services and maintain customer loyalty.

In the Complainants' Questionnaire, which is sent out by the ISO Office to every Complainant, the following question is asked:

**3. How much information did you receive from your insurance or savings company about**

- its internal complaints procedure?  

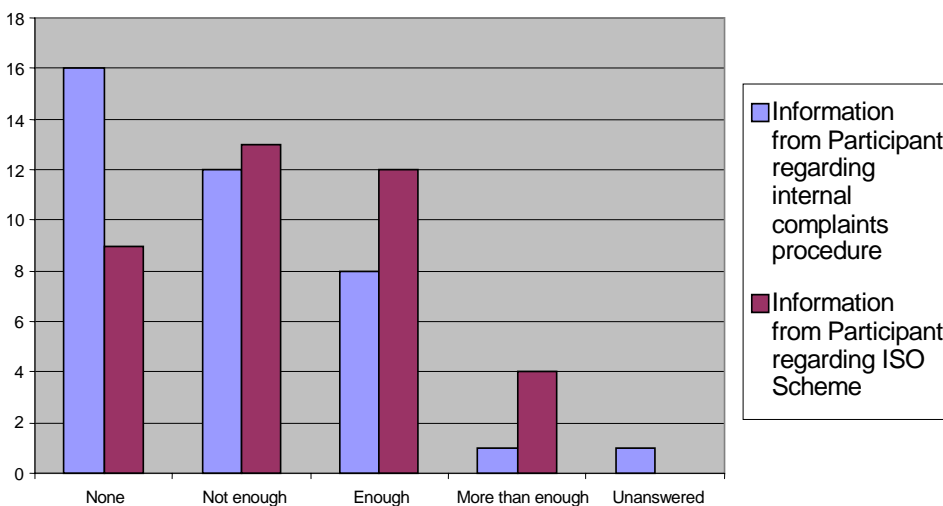
None	Not enough	Enough	More than enough
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
  
- the ISO Scheme?  

None	Not enough	Enough	More than enough
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

From 1 October 2001 to 1 July 2002, we investigated and closed 164 complaints. We received 37 responses to the questionnaire from 15 October 2001 to 3 July 2002.

Only 9 of the 37 responses indicated that Complainants had received enough or more than enough information relating to the company's own internal complaints procedure from the Participant, while 16 indicated that the Participant had provided enough or more than enough information about the ISO Scheme. Of great concern to the ISO are the 16 who indicated they received no information regarding the company's internal complaints procedure from the Participant and 9 who stated they received no information regarding the ISO Scheme.

**Quantity of information Complainant received from Participant regarding internal complaints procedure and ISO Scheme**



A customer-focused approach to complaints handling means that the procedures should be publicised and Participants' staff should know about them. A Participant's membership of the ISO Scheme should be of interest to consumers, because a free dispute resolution service adds value to the relationship. For that reason, we believe Participants should want to publicise their complaints handling procedures and the service offered by the ISO Scheme.

*Case Study 3 continued*

of the conversation, P noted that C's knee was excluded, because it was "to[o] soon" after the surgery.

Just before he was due to depart for the cruise, C developed a blood infection in his knee ("the infection") and had to undergo further surgery for it. Accordingly, C's wife cancelled their travel plans and made a claim to P for the non-refundable portion of the travel costs.

P declined the claim, because it believed the infection was a direct complication of the surgery, which was excluded under the policy.

The policy excluded claims arising "directly or indirectly" out of "[a]ny physical defect, condition or disease" of which C was aware or for which he had received "medical treatment, medical advice" or "prescribed medication", in the 30 day period before purchasing the travel and up until C's departure from New Zealand.

The court addressed the interpretation of the phrase "directly or indirectly" in the case of *Coxe v Employers Liability Assurance Corporation Ltd.* [1916] 2 KB 629, in which Scrutton J stated at page 634, as follows:

*"...the only possible effect which can be given to those words is that the maxim causa proxima non remota spectatur is excluded and that a more remote link in the chain of causation is contemplated than the proximate and immediate cause."*

Therefore, the use of the words "directly or indirectly" changes the usual presumption that an insurer is only liable for losses, which are proximately caused by the risk insured against. This means that, even if the infection, which caused C to cancel his travel plans and make the claim to P, was not directly linked to the surgery, providing P could show that it was indirectly linked to the surgery, the claim would still be excluded under the policy.

P asked C's doctor for more information about the infection. C's doctor stated that the infection was "a direct complication of [the] knee surgery".

Accordingly, the Case Manager believed that P had correctly declined the claim on the basis it was excluded under the policy, because the infection arose directly as a result of a condition of which C was aware and for which he had received medical treatment, in the 30 day period before purchasing the travel.

The ISO Office has brochures available for distribution by Participants containing information about “*How can the Insurance & Savings Ombudsman help you?*”. The time to provide the ISO’s brochure or the Participant’s information about its internal complaints process, is prior to the formal complaint being made. The aim is to keep a customer by managing and resolving the complaint, rather than lose a customer through delay, frustration and mismanagement of the complaint.



## Duty of Disclosure for Life Insurance

There is a special aspect to the duty of disclosure where life insurance is involved. If, after completing a proposal and before the company had gone on risk, the life insured obtains medical advice about a condition which was not present and/ or not disclosed when the proposal was completed, this needs to be disclosed to the company. Many proposals state that the company is not on risk until the required premium has been paid. The most common interpretation of such a provision is that there is no contract until the company has accepted the risk (by completing its underwriting process), the acceptance terms have been accepted by the applicant and the required premium has been paid. Until this occurs, the duty of disclosure continues to apply. In some situations, subsequent claims have been declined because of the failure to disclose information in this period, which would have been material to the company’s underwriting decision.

See Case Study 4



### Review of the Insurance & Savings Ombudsman Scheme

The Insurance and Savings Ombudsman Commission, in accordance with the Rules under which it operates, has appointed an independent committee to conduct a review of the operation of the Insurance & Savings Ombudsman Scheme.

The Review Committee is seeking submissions from the public about the extent of knowledge about the Scheme, how people can access it, and the efficiency and effectiveness of procedures and practices adopted in dealing with insurance industry complaints.

Submissions should be sent to The Chairperson, Insurance & Savings Ombudsman Scheme Review Committee, P O Box 10-845, Wellington or e-mailed to [reviewcommittee@iombudsman.org.nz](mailto:reviewcommittee@iombudsman.org.nz).

The last date for submissions to be received for consideration is 31 August 2002.

#### For More Information:

Stuart Macaskill  
Chair, Review Committee

### Case Study 4

In January 1999, after a mortgage application had been approved, a proposal for life insurance cover with P was completed. The proposal declaration required the life to be insured to advise of any changes in the information provided before the policy was issued. It also stated that P would not be on risk until it had accepted the proposal, the terms had been accepted by C and the first premium had been paid.

In May 1999, the life to be insured died. P subsequently declined the claim because, prior to the life to be insured paying the first premium in March 1999, he consulted his doctor in February 1999. P advised the solicitors representing the estate that, because the contract had not commenced, the life to be insured had a duty to inform P of this visit, the treatment, the advice received and of the further investigations planned. Had this occurred, P stated it would have deferred its offer of cover until all investigations were complete.

C, the administrator of the life to be insured’s estate, believed that, because English was his second language, the life to be insured would not have understood the proposal declaration if it had been read out to him, without being translated into his first language, or if it had been left with him to read.

The Case Manager noted that, although the life to be insured was not born in New Zealand, he had lived here for 26 years. In addition, 2 of the people the Case Manager spoke to indicated they did not have any difficulty in communicating with the life to be insured, in English. However, it was not possible to contact the person who assisted in the completion of the proposal to obtain comment on the degree to which the proposal declaration may have been discussed.

The Case Manager provided 3 insurers with the reason for the February 1999 visit to the doctor. Each insurer advised that the information C failed to disclose was material. The Case Manager concluded that the life to be insured’s failure to advise P of the visit to the doctor in February 1999, was material to P and it was entitled to avoid the proposed policy for non-disclosure.

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